TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH DBA INJURY 1-DALLAS

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-16-1020-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT Code 90837 was preauthorized, #1719XXX therefore it is deemed medically necessary."

Amount in Dispute: $199.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: " There is a pending extent issue set for CCH on 1/21/16...To the extent that there has been no final resolution of this liability dispute and in accordance with 28 TAC Sections 133.307 (e) and/or 133.308(j), any request for resolution of a fee dispute and any request for an IRO must be held in abeyance until such liability disputes have been resolved by a final decision of the DWC."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 8, 2015	90837	$199.50	$199.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. 28 Texas Administrative Code §134.203 sets out the Medical Fee Guideline for Professional Services.
4. 28 Texas Administrative Code §133.240 sets out the procedures for Medical Bill Processing/Audit by Insurance Carrier.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 216- Based on the findings of a review organization

Issues

1. Did the insurance carrier submit documentation to support their position indicated in the insurance carrier's response to the DWC060 request?
2. Did the requestor submit documentation to support that CPT Code 90837 rendered on July 8, 2015 was preauthorized?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier in their position summary states in pertinent part, "There is a pending extent issue set for CCH on 1/21/16..."

   To determine whether such an extent-of-injury or related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Tex. Admin. Code § 133.240(e)(1), (2) (C), and (g) addressed actions that the insurance carrier was required to take, during the medical bill review process, when the insurance carrier determined that the medical service was not related to the compensable injury: 31 TexReg 3544, 3558 (April 28, 2006). Those provisions, in pertinent parts, specified: Former 133.240 (e) (1), (2) (C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division.... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was ... (C) unrelated to the compensable injury, in accordance with § 124.2 of this title... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code § 409.021, and § 124.2 and 124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that: (3) the condition for which the health care was provided was not related to the compensable injury.

   The Division finds that the carrier failed to raise the issue in accordance with DWC rules for disputed CPT Code 90837. Therefore, has waived the issue of extent-of-injury for this dispute. As a result, MFDR has jurisdiction over the disputed issues, pursuant to Texas Labor Code 413.031.

2. Review of the submitted documentation finds that the requestor seeks reimbursement for CPT Code 90837 rendered on July 8, 2015. The insurance carrier denied CPT Code 90837 with denial reason code "216-Based on the findings of a review organization." Review of the submitted information finds the following:

Specific Request	Individual psychotherapy x 4 sessions (to be scheduled bi-weekly)
Category	Psych
Reference #	1719287
Start Date	06/30/2015
End Date	10/30/2015

   28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program..." Review of the CMS-1500 documents that the requestor billed CPT Code 90837 on July 8, 2015. The AMA CPT Code book defines CPT Code 90837 as "Psychotherapy, 60 minutes with patient and/or family member."

   Per 28 Texas Administrative Code §134.600 "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (1) listed in subsection (p) or (q) of this section only when the following situations occur." The Division finds that the insurance carrier preauthorized the disputed service rendered on July 8, 2015. As a result, the insurance carrier's denial is not supported. The disputed service is therefore reviewed per the applicable Division rules and fee guidelines.

3. Per 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   The MAR reimbursement for CPT Code 90837 is $199.50, as a result, the requestor is entitled to reimbursement in the amount of $199.50 for disputed date of service July 8, 2015.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $199.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $199.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		January 22, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.